

PENNSYLVANIA STATE BOARD OF PHARMACY
PO BOX 2649
HARRISBURG, PA 17105-2649
(717) 783-7156
www.dos.state.pa.us/pharm

SATELLITE PHARMACY APPLICATION # 854 110 (Rev 7/09)

Check one:

- New satellite pharmacy...\$125.00 fee
- Change in location of an existing satellite pharmacy...\$125.00 fee
- Remodel of an existing satellite pharmacy...\$125.00 fee

Make fee payable to the "Commonwealth of PA." Fees are not refundable. Note: A processing fee of \$20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

This application must be reviewed for acceptability by the Board of Pharmacy's Floor Plan Review Committee. Construction may not begin on the satellite pharmacy until the application is approved. Notice of approval will be mailed to the contact person. If the Board objects to the application, notice of disapproval will be sent to the contact person and construction may not begin until the discrepancy is resolved.

Name of hospital pharmacy: _____

Pharmacy permit number: _____

Address of pharmacy: _____

Street

_____, PA _____

City

Zip Code

Contact person's name: _____

Contact person's phone number: _____

Contact person's fax number: _____

Contact person's e-mail address: _____

Expected date satellite pharmacy will be ready for inspection: _____

VERIFICATION

The statements in this application are true and correct to the best of my knowledge, information, and belief. I understand that false statements are subject to the penalties of 18 PA C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate. I verify that this form is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information pursuant to 18 PA C.S. Section 4911.

Signature of Registered Pharmacist Manager and Date

AND

Signature of the (check one below) and Date:

- Registered Agent of Corporation
- Registered Agent of LLC
- Hospital/Nursing Home Administrator
- Individual Owner

Beginning with the pharmacist manager, list all registered pharmacists employed at the above pharmacy. If more space is needed, additional 8 ½" x 11" sheets of paper may be attached.

Name	License Number	Exp. Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

A satellite pharmacy is defined as a pharmacy in an institution which provides specialized services for the patients of the institution and which is dependent upon the centrally located pharmacy for administrative control, staffing, and drug procurement. The term does not include a pharmacy serving the public on the premises of the institution nor does it include a pharmacy located off premises from the centrally located pharmacy of the institution regardless of whether the pharmacy is owned by the same person or entity which owns the institution.

What specialized services for the patients of the institution will the satellite pharmacy provide?

Is the satellite pharmacy in the same building as the central hospital pharmacy?

Yes () No ()

If your response is "No", please provide an explanation: _____

Please note the exact location of the central hospital pharmacy: _____

Please note the exact location of the proposed satellite pharmacy: _____

Please note the distance between the central hospital pharmacy and satellite pharmacy: _____

A satellite pharmacy that fails the inspection will be required to pay \$115.00 for re-inspection. It will be the responsibility of the pharmacy owner to notify the Board office in writing when the satellite pharmacy is ready for re-inspection.

Correcting any deficiency or violation noted on the inspection report will be the responsibility of the owner. The Board will grant a period of not more than thirty days to correct the deficiency. Failure to do so will be just cause for the Board to take other appropriate action.

It is your responsibility to maintain a copy of this and all documents submitted to the Board or received from the Board for your future reference.

If this application is in order but the satellite pharmacy has not passed its required inspection within one year of the original date of submission of this application, the Board may request submission of a new application or part of an application along with the required application fee.

Please draw a skeleton sketch showing the floor plan and dimensions of the proposed satellite pharmacy. Blue prints will not be accepted in lieu of this sketch. Also, please indicate the placement of any relevant items such as counters, a sink or a refrigerator if these items will be present. Additional 8 ½" x 11" sheets of paper may be attached if more space is needed.

